[San Francisco]

MAYOR'S TASK FORCE ON THE MENTALLY ILL

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REPORT BY THE MAYOR'S TASK FORCE ON THE MENTALLY ILL

Rotea J. Gilford, Chairman

February, 1985

BACKGROUND

Concerned with the growing number of mentally ill persons inundating our mental health and criminal justice systems, Mayor Dianne Feinstein appointed a 21 member Task Force to assess this situation and develop recommendations to address the identified problems.

The entire Task Force met six times since its inception on October 25th. Subcommittees were also established to intensively investigate specific areas related to mental health including legal problems, facility capability and needs, resource availability and processing of the severely mentally disabled. Presentations were made to the Task Force by the Chairman of the Mental Health Advisory Board regarding the Board's perspective on various issues and by representatives from the Juvenile Justice Commission regarding youth-related matters. Written input was also received from several other organizations and citizens, generally expressing their support for the establishment of a L-Facility within San Francisco.

Outlined on the following pages is a listing of the specific findings and recommendations developed by the Task Force. While the Task Force has recommended that certain new programs be established, it should be noted that they did not review nor approve specific budgets necessary to implement these services.

Finally, the Task Force also identified several issues that warrant further attention and recommend that an ongoing committee of interested professionals be established by recommendation of the Health Commission to further study these selected areas. These issues are enumerated in Section E.

SUMMARY OF RECOMMENDATIONS

1) A minimum 99-bed locked sub-acute facility should be developed for involuntary clients at San Francisco General Hospital on a site deemed most feasible by the Department of Public Works. If this site becomes unfeasible, every effort should be made to find another location in San Francisco. (The Department of Public Works has conducted a preliminary analysis of the estimated cost of developing a L facility at San Francisco General Hospital. See page 11A).

2) An additional 25 acute beds should be established at SFGH for placement of the severely mentally disabled (this supplemental is already in process). A minimum of 2 beds will be set aside for exclusive use of the SFPD for 5150's

3) Effective February 1st, a special CMHS unit will be created from existing resources to vigorously screen for residency on a pilot basis. This unit will evaluate for residency all patients receiving emergency treatment. Those patients found not to be San Francisco residents will be returned to their counties of origin, accompanied by CMHS staff when indicated.

4) The Mission Crisis Service will operate expanded hours in order to evaluate voluntary emergency patients. San Francisco General Hospital, Psychiatric Emergency Services will only see involuntary patients.

5) Procedures will be developed to eliminate, to whatever extent possible, the practice of diversion of police initiated 5150's. These procedures will be developed and implemented within the next 3 to 6 months.

6) The County Jail will continue to be used only for those detained for Commission of public offenses and should not be used to house the mentally ill in lieu of housing in acute facilities.

7) A centrally controlled placement unit will be initiated on February 15 at CMHS. This unit will initiate, approve, and monitor referrals and placements to all residential facilities that are a part of CMHS.

8) An expanded drop-in, crisis clinic should be developed in the Tenderloin (16 hours/day) for voluntary patients.

9) The current planning for sub-acute care should recognize the need for 20 beds of that type for adolescents.

10) An adolescent in-patient bed at McAuley should be identified for the exclusive use of young people from Juvenile Hall who require acute care hospitalization.

11) Another adolescent day treatment program for approximately 20 adolescents should be developed.

12) Regional planning should take place for the development of additional involuntary sub-acute beds. State funding assistance should be sought for these programs.

13) Develop additional residential treatment facilities for San Francisco's emotionally disturbed young people.

14) Support the efforts of State Mental Health, Social Services and School Department officials to rewrite State regulations governing funding of residential treatment facilities for young people.

15) A plan should be devised which would provide augmentation of State funding for residential treatment facilities in order to prevent further closures, loss of operating licenses and loss of neighborhood acceptance of existing residential treatment facilities while the new funding regulations are being redrafted.

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A. HANDLING OF 5150'S*

Findings:

1) The Police Department responded to 18,000 calls regarding incidents involving mentally disturbed individuals during the last year. This resulted in about 2,000 involuntary detentions for psychiatric evaluation under section 5150 of the W&I Code; the remaining 16,000 calls were handled by the Police by arrest or other disposition. In some of these cases, the Police were called for assistance by various agency case workers even though no criminal or violent behavior had been committed by the individual.

2) Approximately 1100 visits/month are made at the psychiatric emergency services at SFGH and Mt. Zion. A recent survey of clients revealed that 4% had addresses in counties outside San Francisco. About 17% were homeless San Francisco residents.

3) There are probably 200-300 mentally ill people milling around the Tenderloin, South of Market and other areas in San Francisco who meet 5150 criteria for grave disability but who are not taken into custody for evaluation because of a lack of resources.

4) In recent months there have been several times when both emergency services have had to close temporarily to police-initiated 5150's. (It was noted that acute beds are sometimes made available to voluntary clients during periods of diversion.)

5) Jail is being increasingly utilized for mentally ill people who have committed minor crimes because of the unavailability of acute beds.

6) The use of vagrancy laws to control the mentally ill would cause severe liability problems for the City, would cause disruption and overcrowding in City jail and only serves as a very temporary solution.

*The term "5150" pertains to any person, who as a result of a mental disorder, is a danger to others, or to himself or herself, or is gravely disabled.

Recommendations

1) An additional 25 acute beds should be established at San Francisco General Hospital for the placement of the severally mentally disabled.

2) Effective February 1st, a special CMHS unit will be created from existing resources to vigorously screen for residency on a pilot basis. This unit will evaluate for residency all patients receiving emergency treatment. Those patients found not to be San Francisco residents will be returned to their counties of origin, accompanied by CMHS staff when indicated.

3) The Mission Crisis Service will operate expanded hours in order to evaluate voluntary emergency patients. San Francisco General Hospital, Psychiatric Emergency Services will only see involuntary patients.

4) An expanded drop-in, crisis clinic should be developed in the Tenderloin (16 hours/day) for voluntary patients.

5) A centrally controlled placement unit will be initiated on February 15 at CMHS. This unit will initiate, approve, and monitor referrals and placements to all residential facilities that are a part of CMHS.

6) Procedures will be developed to eliminate, to whatever extent possible, the practice of diversion of police initiated 5150's. These procedures will be developed and implemented within the next 3 to 6 months.

7) The County Jail will continue to be used only for those detained for Commission of public offenses and should not be used to house the mentally ill in lieu of housing in acute facilities.

B. YOUTH ISSUES

After numerous meetings with representatives from the health department, Department of Social Services, Board of Education, Juvenile Court, and others, a proposal was prepared to address the needs of severely mentally ill youth in San Francisco.

It is recommended that members of this work group be incorporated in order to address this very critical segment of people in need of some assistance.

Recently several major developments have had a profound impact on the availability of appropriate treatment programs for severely mentally ill San Francisco youngsters. These developments include:

1. The closing of Youth Campus, which was providing residential treatment to about 25 youngsters when it closed;

2. Changes in policies so that parents can no longer voluntarily relinquish custody of their mentally ill children in order to obtain public funding for residential treatment.

3. The Christopher T. lawsuit which is based on federal legislation mandating a free public education (which may require residential treatment) for handicapped youngsters, including those with psychiatric disabilities.

I. JUVENILE HALL'S MENTAL HEALTH PROBLEM AREAS

With few exceptions, youth detained in Juvenile Hall are at risk because of the lack of structure, supervision and support in their home and community environments. Many of these youth commit the anti-social acts which lead to their detention because of underlying emotional disturbances. Once detained, all youth are thrown into disequilibrium by their separation from family, friends, community and the familiar day-to-day routines of their lives.

All of these circumstances are further exacerbated by the waiting and wondering which are the hallmark of time in detention. In light of this, mental health needs of all detainees must be carefully considered and conscientiously responded to.

Three categories of youth in detention in Juvenile Hall can be identified. Each group has different mental health needs which are currently not being adequately addressed.

1. The first category of youths includes those who are properly detained by the Juvenile Court but are exhibiting such severe emotional disturbances that their needs cannot be adequately or safely met outside of an acute care psychiatric facility.

There are two major problems in responding to detainees in need of acute psychiatric care. The first is the decertification and premature discharge of such young people which is described in detail below. The second problem lies in the fact that beds are not always immediately available in acute care settings. This leaves those detainees seriously in need of psychiatric hospitalization waiting in Juvenile Hall for an acute care bed to become available.

2. The second category is composed of youth who are properly detained by the Juvenile Court, and while not exhibiting emotional disturbances to the extent that acute-care hospitalization is necessary, they can neither be safely housed nor adequately served in the Juvenile Hall.

This second group of detainees has been described as "behavior management problems," and much attention has been afforded them in view of the seriousness of their difficulties and the anxiety and frustration they engender both within the staff and their fellow detainees. These youth tend to be depressed, agitated and in need of close observation for suicidal feelings or impulsive behavior. This group often contains youth in need of psychotropic medication or youth at high risk for further deterioration without psychologically trained staff to intervene.

These youth are representative of a larger group of San Francisco youth in similar need of sub-acute mental health facilities. Many of these youth have failed a number of placements, often because they were placed inappropriately in the absence of available sub-acute facilities. Another portion of these youths has been properly discharged from McAuley because they no longer require acute-care hospitalization but soon deteriorate in Juvenile Hall because they require sub-acute care, not detention.

In light of the problems posed by these youth, and in recognition of the fact that their needs are not being met in Juvenile Hall and acknowledging that these youth are representative of a larger group of youth in the city, it is imperative that sub-acute facilities and services for all of San Francisco's sub-acutely disturbed youth be developed.

3. The third category is composed of all other youth detained in Juvenile Hall who are not exhibiting emotional disturbances warranting acute or sub-acute care but are experiencing emotional distress by the very fact and circumstances of their detention and protracted disposition.

Typically, these youth react to detention with sadness and anxiety which often results in problematic behavior. Those with strengths adjust, while others must be assisted in their adjustment by counselors adept at clarifying what to expect while in detention. This group of youth often turn out to be "good" detainees, and the experience of detention becomes a one-time lesson.

At the present time, this third category of detainees' mental health needs are not being adequately addressed because staff are pre-occupied with the first two categories of detainees.

II. IDEAL CONTINUUM OF MENTAL HEALTH RESOURCES

The ideal continuum of mental health resources for San Francisco's emotionally disturbed youth is as follows:

1) Acute Psychiatric Care - locked setting

2a) Napa State Hospital

2b) Sub-Acute Care - locked facility

3) Residential Treatment - open setting

4) Family, Group or Foster Home with Day Treatment

5) Family, Group or Foster Home; attendance at regular school, weekly out-patient psychotherapy

Graduation from the Mental Health System

Although young people will enter this system at different points, depending on the severity of their emotional disturbance, the lack of adequate resources at each subsequent level of transition is a problem for nearly all emotionally disturbed young people in San Francisco.

III PROBLEM AREAS

1. Acute Care: Although beds are fully utilized, at this point an adequate number of beds exist, but funding regulations lead to decertification and premature discharge.

At the present time the majority of these prematurely discharged young people are returned to dependency shelter (Children's Home Society) emotionally disturbed young people. Typically, these youngsters decompensate in these inappropriate settings, leading to their return to acute care facilities where they stabilize, leading to decertification,

leading to their return to Juvenile Hall or dependency shelter care, etc. This revolving door cycle continues while Bay Area placement workers scramble for spaces in an already inadequate, ever-shrinking pool of placement resources.

There appears to be no realistic hope of changing state regulations governing funding of acute care lengths of stay. If San Francisco had a sub-acute care facility for young people who are currently caught up in the above-described cycle, these young people would have an appropriate place to go once they have stabilized in acute care settings.

2a. Napa State Hospital: There are enough beds at Napa for our needs, but the regulations governing access to these beds result in our inability to admit all young people in need of state hospital care at the time they need it. The main problem with Napa State Hospital for San Francisco lies in our lack of resources for young people who are ready to return to our community; i.e., young people returning from Napa cannot simply go home abruptly following lengthy residence in a state hospital; they need transitional placements which we do not have.

The result of this dilemma takes one of two forms: (a) Young people ready to be discharged are kept at Napa longer than necessary while they await openings at residential treatment centers. This is not fair to these young people, and state utilization regulations dictate that we must discharge a percentage of patients in order to admit new patients. This leaves those young people awaiting placement at Napa vulnerable to the revolving door cycle described in 1 above. (b) If young people are discharged from Napa when they are ready to go home, they are often discharged home without adequate structure or therapeutic assistance while they await openings in residential treatment or day treatment facilities. These young people frequently decompensate under these circumstances, resulting in re-admission to acute care facilities and, in some cases, a return to Napa.

If we had a sub-acute facility for children in San Francisco, significantly fewer children would require hospitalization in Napa, and we would have a place for young people returning from Napa to transition to.

2b. Sub-Acute Care: Non existent.

If San Francisco had a sub-acute facility for young people, it would end the revolving door cycle described above, fewer young people would need hospitalization at Napa and young people could come home from Napa sooner.

State mental health officials explained that Napa has fallen into a state of disrepair. They are currently in the process

of seeking funding for a major renovation project. If we could show that we would send fewer children to Napa, it would save the State money on their remodeling because they would need a smaller Children's ward. It is because of this that the State has offered to assist us with capital start-up costs for a sub-acute facility. Local clinicians and directors of sub-acute facilities for children have advised that of 20 or so young people currently in Napa (all of whom local clinicians know personally), two thirds could come home now if we had a sub-acute facility. Another two thirds could come home within the year, and another two or three will probably never be able to come home.

3. Residential Treatment: Inadequate resources.

Because the expense of operating a residential treatment facility in the Bay Area is greater than State subsidy for such care, residential treatment facilities in San Francisco have been closing their doors at an alarming rate. In the absence of adequate residential treatment resources, emotionally disturbed young people find themselves "waiting and wondering" in Juvenile Hall with no sense of when they will be moving on. Bay Area placement personnel must become marketing experts as they compete with each other for ever-shrinking resources for their young charges.

Too often the anxiety of waiting in inappropriate settings wears these young people down until they require a more acute level of mental health care than they needed when they first came within the jurisdiction of the Juvenile Court or the Department of Social Services.

Judge Hanlon's mental health sub-committee has been working with State officials to help them to understand our resource crunch. This sub-committee has been invited to participate in the re-writing of State funding regulations governing residential treatment centers. This could help our situation, but it would not be enough if the State changed its funding regulations and we had no residential treatment facilities for the children to go to.

4. Day Treatment Facilities: Inadequate resources.

As with the other groups of young people described above, the lack of adequate numbers of slots in day treatment centers leaves young people in inappropriate settings where they frequently regress, requiring a higher level of acuity of care than they did initially.

IV. FUNDING ISSUES

1. Acute Care Hospitalization: So long as children are

acutely psychotic, they are subsidized through the Medi-Cal system. Typically, the Medi-Cal decertification occurs after a child has only minimally stabilized. Short-Doyle funds are used to extend the length of stay allowing some consolidation of clinical gains achieved under the Medi-Cal funded period. Short-Doyle funds are inadequate; most hospitals with Short-Doyle contracts with the City receive their share in July and use it up by September. Once there is no more Short-Doyle funding, hospitals must absorb the cost of each day a child is hospitalized after that. Thus, there is a tremendous imperative to discharge children as soon as possible despite the lack of resources for them to be discharged to.

2. Residential Treatment: Delinquent and dependent children are subsidized by the Department of Social Services. Those few children whose need for residential care is a direct result of an educational handicap are subsidized by the School Department. These children do have an agency responsible for their financial support in residential treatment, although, as mentioned above, the subsidy is inadequate for the City's cost of living rate.

If children are neither dependent, delinquent nor educationally handicapped, there is no public funding available for them. It is this situation which led to the Christopher T. lawsuit; i.e., in order to gain access to a public funding source, the parents of these children must go to court and state that they are unable to provide for the special needs of their children. Their children then become dependent children of the Juvenile Court and funding becomes available. Because dependency is generally associated with parental abuse, neglect or abandonment, these parents do not want to declare their "unfitness" to care for their children in order to qualify for public funding for their Children's residential treatment needs. The Christopher T. Committee has proposed a plan to abolish this system, and this system is uppermost in the minds of the sub-committee which is assisting in the redrafting of State funding regulations. Hopefully, these two efforts will put an end to this problem.

3. Day Treatment: This service is funded through Medi-Cal and Short-Doyle funds, but because the daily cost for day treatment is significantly less than the daily in-patient rate in an acute care setting, the money available is enough to subsidize the care needed.

Recommendations

1. Include the need for 20 adolescent beds in the current planning for sub-acute care.

2. Develop another adolescent day treatment program for approximately 20 adolescents.

3. Establish an adolescent in-patient bed at McAuley for the exclusive use of young people from Juvenile Hall who require acute care hospitalization.

4. Develop additional residential treatment facilities for San Francisco's emotionally disturbed young people.

5. Support the efforts of State Mental Health, Social Services and School Department officials to rewrite State regulations governing funding of residential treatment facilities for young people.

6. Devise a plan which would provide augmentation of State funding for residential treatment facilities in order to prevent further closures, loss of operating licenses and loss of neighborhood acceptance of existing residential treatment facilities while the new funding regulations are being redrafted.

C. ESTABLISHMENT OF L FACILITY

Findings

1) From 25-30% of all CMHS hospital beds are occupied by patients awaiting placement in less expensive or intensive programs. It is estimated that at any one time 100 patients of all ages are being held for involuntary treatment who could be more appropriately placed in other programs. This target population would derive maximum benefit from a newly developed residential program if it is located in San Francisco. A locally based program provides ready access for family, friends and clinicians as well as facilitates linkage to other mental health services which can gradually lead to a patient's resumption of independent living.

Recommendations

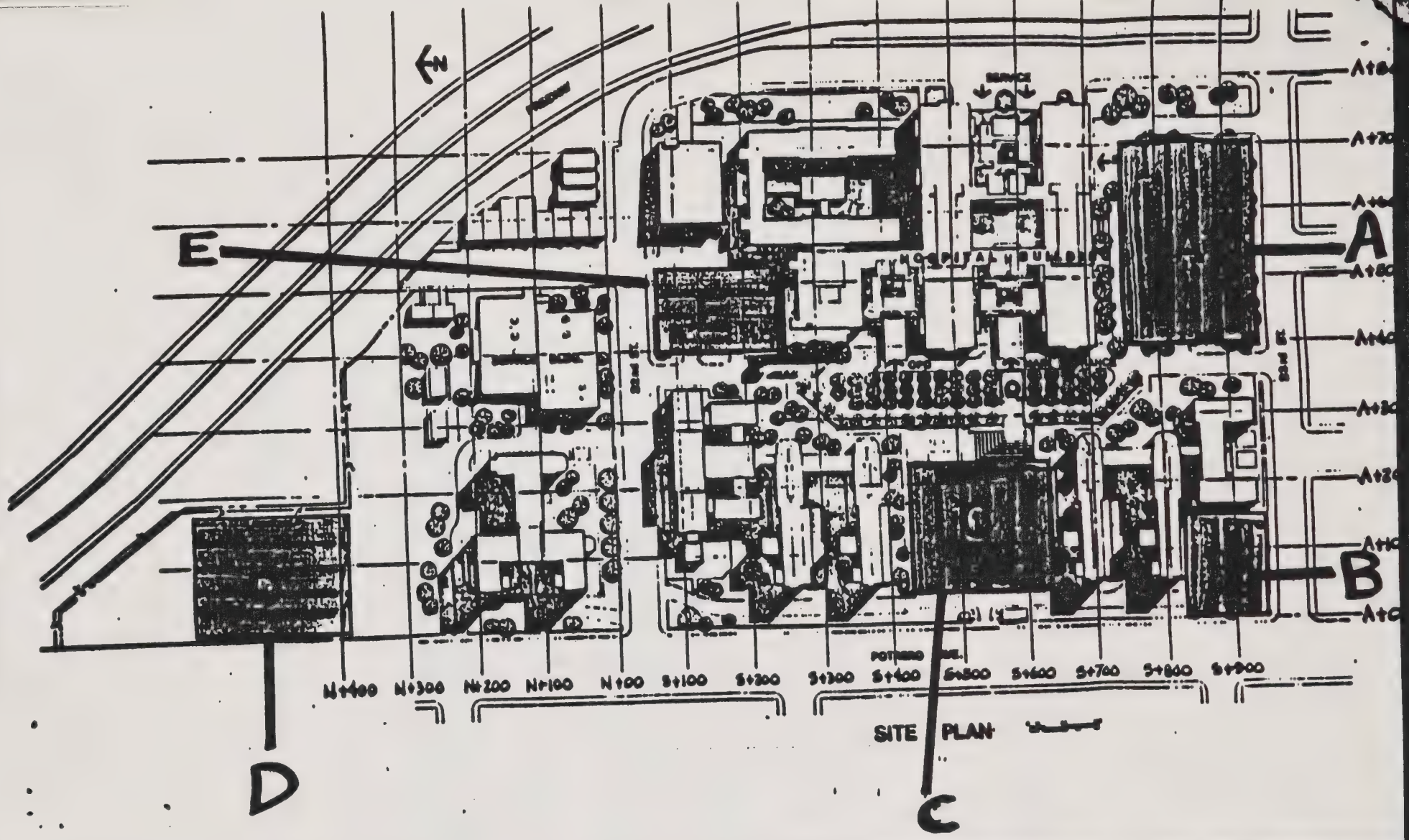
1) A mimimum 99-bed locked subacute facility should be developed for involuntary clients at San Francisco General Hospital on a site deemed most feasible by the Department of Public Works. If this site becomes unfeasible, every effort should be made to find another location in San Francisco. (The Department of Public Works has conducted a preliminary analysis of the estimated cost of developing a L facility at San Francisco General Hospital. See next page).

Outlined below is a tabular presentation of five potential locations for parking and/or L-facility structures at SF General Hospital. Sites A, C and D would support both uses; however, Site C might not be acceptable architecturally. Sites B and E would only support parking. Also attached is a plot plan of SFGH indicating these specific sites.

LOCATION	EXISTING PARKING CAPACITY	TYPE OF STRUCTURE/ PARKING CAPACITY	AREA	COST	COST PER SPACE	COMPARATIVE CO PER SPACE BASE ON INCREASE
**A) 23rd Street South of SFMC	164	Above Grade/ Open Sides / 450 3 levels /	55,000 sq ft./ level	$5.7 Million	$12,666	$20,400
B) NE Corner 23rd & Potrero	0	Underground/ 2 levels / 50	14,000 sq ft./ level	$2.1 Million	$26,250	$26,250
**C) Potrero Ave btwn 22nd & 23rd St	0	Underground/ 600 3 levels /	70,000 sq ft./ level	$13.6 Million	$22,666	$22,666
* *D) Potrero Ave No. of 22nd Street	200	Underground/ 3 levels / 770	40,000 sq ft./ level	$15.4 Million	$20,000	$29,600
E) 22nd Street South side	42	Above Grade/ Open sides / 150 3 levels /	19,600 sq ft./ level	$2.1 Million	$14,000	$21,000

*Could be two levels underground, would provide 510 stalls at $10.8 million.

**L-Facility will fit on top, cost not included.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SITE PLAN

D. OTHER SUBACUTE FACILITIES

Findings

1) CMHS has access to approximately 570 beds in involuntary residential treatment programs for the placement of clients. All but 100 of these beds are located outside of San Francisco.

2) There is a critical shortage of involuntary subacute beds throughout the Bay Area.

3) CMHS has access to approximately 1050 beds in voluntary residential programs which include board and care homes, halfway houses and supervised apartment units. These facilities cannot accommodate the current demand for service; clients leaving involuntary residential programs for placement in voluntary programs must often wait several weeks for openings.

4) Marginal patients seeking brief hospital treatment often must become acutely ill before intensive treatment can be provided to them. This often results in more or longer hospitalizations.

Recommendation

1) Regional planning should take place for the development of additional involuntary subacute beds. State funding assistance should be sought for these programs.

E. ISSUES FOR FURTHER STUDY

The Task Force recommends that an ongoing Committee of interested professionals be established by recommendation of the Health Commission to further study the following issues:

1. In order to alleviate the level of police interaction with the mentally ill, a proposal has been developed to establish a Mobile Crisis Unit within CMHS. The Mobile Crisis Unit would receive emergency calls from police and crisis clinics and begin emergency evaluation and treatment immediately upon reaching the patient. The Unit would initiate 5150 procedures whenever necessary and provide transportation to crisis clinics or in-patient units (see Appendix I for more details).

2. Psychiatric and medical care, as well as life support needs --food, clothing and shelter-- are provided in San Francisco by a complex combination of income maintenance and support services. A great many of the most psychiatrically disabled adults need special assistance from skilled advocates in order to gain access to Medi-Cal/SSI and other entitlements for which they are eligible. The implementation of such an advocacy service could generate cost savings for the City by reducing the demand on General Assistance and City-supported medical and psychiatric services (see Appendix II).

3. It was felt that major expansions are necessary in voluntary residential programs, and early intervention, day treatment and outpatient services; these programs will subsequently reduce pressure on the need for involuntary programs. Specialized programs are also needed for mentally ill felons, 180 day post-certification and not guilty by reason of insanity patients as well as for clients who are both mentally ill and serious substance abusers.

4. The City-funded non-profit agencies which are providing emergency shelter to the homeless consistently report the referral of mentally and physically disabled persons from various hospitals and clinics to their shelters. These persons cannot be properly accomodated at the shelter sites and more appropriate services need to be identified for this population.

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SAN FRANCISCO MOBILE CRISIS UNIT

Jess H. Ghannam, Ph.D. Gail L. Gresham, RN, MS, JD

DESCRIPTION OF SERVICE

The San Francisco Mobile Crisis Unit (SFMCU) will:

1. make on-site psychiatric evaluations and, if required, utilize physical and/or pharmocologic procedures in restraining patients with acute psychiatric disorders (for example, suicidal patients and/or patients experiencing acute psychotic decompensations who pose a threat to the safety of the public.); have 5150 privileges and be able to transport patients, already evaluated, to appropriate facilities,

2. provide a minimum of four holding beds for psychiatric patients in situations where both crisis clinics are on diversion; improve patient care as patients will no longer be left by police without careful psychiatric evaluation; act as a temporary crisis facility until arrangements can be made to transport patients to a psychiatric service or other community facility,

3. provide immediate psychiatric coverage of individuals who are unable to get to an emergency facility or who, because of the gravity of their disturbance, are precluded from getting to a crisis clinic (for example, individuals who have locked themselves in their rooms in an acute psychotic or suicidal state or who have decompensated at board and care homes or in shelters),

4. act as a liason for the San Francisco Police Department, California Highway Patrol, and the community mental health system,

5. offer training courses to police and fire department personnel on the rapid diagnosis and intervention of acute psychiatric emergencies and the legal issues concerning the treatment of individuals in mental health facilities,

6. offer a city-wide emergency back-up service that is flexible and able to interface with other community mental health services in San Francisco.

PROCEDURE

San Francisco Mobile Crisis Unit will:

1. receive emergency calls from police communications, crisis clinics or other referral sources,

2. begin emergency evaluation and treatment immediately upon arrival at the site and initiate 5150 procedures whenever necessary,

3. call police for back-up purposes only in the case of violent and/or assaultive patients or if the most appropriate referral is to the criminal justice system (after the containment phase , the police may immediately leave to return to their duties),

4. provide appropriate disposition such as return to the community, to crisis clinics for on-going evaluation or brief treatment, to in-patient units receiving psychiatric emergencies or to other appropriate referral sources.

STAFFING

San Francisco Mobile Crisis Unit will include:

1. co-directors, one administrative and one clinical, who will be directly responsible for overall function, delivery of direct service, research, and education,

2. one trained paramedic who can respond to medical emergencies, administer medication, and assist in the restraint of violent or assaultive patients,

3. one mental health professional who may be a psychologist, psychiatrist, registered nurse or clinical social worker trained in the area of rapid diagnosis and intervention of acute psychiatric conditions,

4. one intake worker with clerical responsibilities.

SERVICE CAPABILITY

Average response time: 22 minutes
Average time for evaluation and disposition: 35 minutes
Average 8 hour capability with one van/two beds: 16 cases;
with two vans/ four beds: 32 cases

PROPOSED BUDGET

For eight (8) hour coverage, seven (7) days/week, 52 weeks/year, using one van with two beds.

Personnel

1.4 FTE paramedic	$28.000.00
.8 FTE mental health professional	$30.720.00
1.0 FTE intake worker/clerical	$16.000.00
.75 FTE clinical director	$45.000.00
1.0 FTE administrative director	$56.250.00
.10 FTE consultant	$ 9.600.00
sub total	$185.570.00

Fixed and Indirect Costs

overhead	unknown:depends on location
gas and maintenance	$15.000.00
supplies	$10.000.00
medications	$10.000.00
communications	$10.000.00
sub total	$45.000.00
Total	**$230.570.00**

Initial Capital Outlay

fully equipped van and emergency equipment	$32.000.00
research and preparation	$20.000.00

F. REPORT AND RECOMMENDATIONS OF THE ELIGIBILITY COMMITTEE OF THE MAYOR'S MENTAL HEALTH TASK FORCE

A special committee was established consisting of representatives from CMHS and the Department of Social Services to review current methods of establishing eligibility for Medi-Cal and/or Supplemental Security Income (SSI) for psychiatricially disabled San Francisco adults. The committee consisted of the following staff:

Allan Leavitt, CMHS
Clifford Berg, CMHS
Fred Milligan, Heath Department
Carolyn Plybon, DSS
Michael Fitzpatrick, DSS

The need for the committee was based on the documented knowledge of Health Department staff that many severely psychiatrically disabled San Franciscans are unable to obtain life sustaining financial benefits for which they are clearly eligible. These benefits are funded by state and federal programs. If disabled San Franciscans cannot establish their eligibility for these programs, they end up receiving financial assistance and medical care totally funded by the City and County. The amounts of lost state and federal benefits are enormous, amounting to millions of dollars each year.

Psychiatric and medical care, as well as life support needs -- food, clothing and shelter-- are provided in San Francisco by a complex combination of income maintenance and support services.

A great many of the most psychiatrically disabled adults need special assistance from highly skilled advocates in order to document and retain their eligibility. Special knowledge of all the complex eligibility requirements is critically important if these clients are to consistently receive Medi-Cal and federal supplemental security income (SSI).

New Program

In order for many additional psychiatrically disabled San Francisco adults eligible for Medi-Cal and/or SSI to receive these entitlements, a new Support, Evaluation, and Advocacy Unit jointly staffed by CMHS and DSS will be required. This new Unit will have three major functions:

1. Substitute Payee Program:

The inability to manage money is the most significant complicating factor preventing the care of mentally disabled individuals. The presence of this single factor often precipitates a downward spiral of lack of food, loss of housing, loss of entitlements and eventually hospitalization for psychiatric and/or medical care.

SSI/SSP recipients are often found in shelters after receiving a check at the beginning of the month. A substitute payee program is effective in curtailing this cycle by making direct payments for rent or residential care, thus ensuring a residence throughout the month, and by cutting a monthly allotment to a weekly one, thereby, in fact, managing a client's money.

2. Eligibility Evaluation and Control

The obtaining of SSI/SSP and Medi-Cal eligibility effectively transfers financial responsibility for income maintenance, medical and psychiatric care to the Federal government where responsibility for the maintenance of permanently disabled individuals legally resides. The savings in local G.A., and medical and psychiatric costs can be enormous as a result of reduced expenditures and increased revenues.

SSI and Medi-Cal disability cases normally take several months to be approved. Much of this time is utilized accumulating psychiatric and medical records. During this time period, many problems arise, especially for applicants applying for disability on a psychiatric basis. Because the patient often cannot be relied upon for documentation of psychiatric medical or financial history, a separate investigative and tracking control is required. Otherwise, data crucial to establishing eligibility is not obtained or submitted.

3. Advocacy Program

The SSI/SSP-Medi-Cal eligibility advocacy program will have two major components. County employees will have access to much more comprehensive medical and psychiatric information to document proof of eligibility. They will handle standard advocacy cases that may require little more than effective communication and clarification. A second component for more complex cases or those requiring technical or legal knowledge may entail private contracting.

Cost Effectiveness Analysis

The new Support, Evaluation, and Advocacy Unit would require about 12 staff. Staffing and other costs would total about

$600,000 a year. Savings in City/County funds can be projected as follows:

a) Psychiatric Hospitalization

CMHS staff currently hospitalize 200-225 patients each month. At least 40 psychiatrically disabled patients each month currently without Medi-Cal (and a total of 300 patients each year allowing for reapplications) could document their eligibility for Medi-Cal if additional staff were available.

The 300 patients utilize at least 400 hospitalizations each year at an average cost of $4,656 per hospitalization. Annual new reimbursements from Medi-Cal would be 400 x $4,656 = $1.8 million.

b) Medical Costs

These same 300 patients require medical treatment at least as costly as their psychiatric treatment each year. Additional medical reimbursements after Medi-Cal eligibility was documented would also be $1.8 million.

c) General Assistance Savings

Currently more than 1,600 G.A. recipients have SSI applications pending. About 800 of these are for psychiatric disabilities. Only about 100 of these 800 applications will be approved with the current system. If the new services listed above were in place, an additional 400 G.A. recipients each year could document their eligibility for SSI. The income for these clients would go from $272 to $470 a month, and City/County savings would total $650,000 each year. This figure was arrived at by assuming that 400 clients currently receive $272 a month from G.A., six months a year.

d) Fiscal Summary

New psychiatric reimbursements after Medi-Cal established	$1,800,000
New medical reimbursement after Medi-Cal established	$1,800,000
General Assistance savings	$ 650,000
Total savings	$4,250,000
Total cost for new system	$ 600,000
Net Yearly Savings	$3,650,000